IDAHO SOUND BEGINNINGS
REFERRAL FOR DIAGNOSTIC AUDIOLOGIC EVALUATION

HOSPITAL: _____Today's Date: _____

BABY'S NAME: _____(M)____(F)____**DATE OF BIRTH:** _____

Mother's Last Name (if different from baby's):_____

- **BABY'S HOSPITAL MEDICAL RECORD #:** [ ]

Results: Inpatient Screen - R_____ L_____ Screening Method: ABR _____ OAE_____

Outpatient Screen- R_____ L_____

- **BABY'S PRIMARY PHYSICIAN**: _____

- **PARENT/GUARDIAN**:

Name:_____

Address:_____

City:_____ State:_____Zip:_____

Phone: _____

- **AUDIOLOGIST/CLINIC REFERRED TO:**

Name:_____

Address:_____

City:_____ State:_____Zip:_____

Phone:_____

DATE OF DIAGNOSTIC EVAL. (if known):_____

RISK INDICATORS:

__Family History (Permanent Childhood Hearing Loss)
__Gestational Age < 32 weeks
__ Syndrome Associated with HL
__Low Birthweight (<3.3 lbs.)
__Congenital Infection (e.g. T-O-R-C-H)
__Postnatal Infection (e.g. Meningitis)
__Hyperbilirubinemia (requiring transfusion)
__Craniofacial Abnormalities
__Low Apgar Scores (<4/1 or 6/5)
__Mechanical Ventilation> 10 days
__Ototoxic Medications
__Other _____

If financial assistance for the audiologic evaluation is needed, information can be obtained by calling the Idaho Care Line at 800-926-2588 (voice), 208-332-7205 (TTY).

I hereby give permission to the staff of the above-named hospital to release medical information necessary to complete an audiological evaluation for my child to the above-named audiologist/clinic (or the audiologist of my choice) and physician. I also give permission to the above named hospital and audiologist/clinic to share information about the results of the hearing screening and diagnostic audiologic evaluation with the staff at my child's birth hospital, the above–named physician, the Idaho Infant-Toddler Program, the Idaho Early Hearing Detection and Intervention Project (EHDI), and Idaho Hands & Voices. I understand that the information will be used to ensure that appropriate and timely medical, educational, and audiologic services are made available to my child. I understand that this information will not be shared with unauthorized individuals.

- **PARENT/GUARDIAN:_____ Date:_____**

(Signature required)

TO THE SCREENER: Please return this form within 10 days* of referral date to:

Idaho Sound Beginnings (EHDI) Project
1720 Westgate Dr., Boise, ID 83704
(208) 334-0983, (800) 433-1323 or FAX: (208) 334-0952

DISTRIBUTION: **White**-Audiologist, **Gold**-EHDI Project , **Yellow**-Physician, **Pink**-Hospital, **Green**-Parent(s)

(If baby does not return for Outpatient Screen, form is to be distributed within 30 days of Inpatient Screen Date)